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14. ABSTRACT The Children's Health Insurance Program (CHIP) in Texas provides basic health insurance to children less than 19 years of age for families that cannot afford private insurance and do not qualify for Medicaid. Studies have shown a correlation between the lack of health insurance and the negative effect on a child's health status. In 2004, financing of CHIP came to the forefront of debate as Texas struggled to overcome a $10 billion dollar budget deficit. Consequently, the 78th Texas Legislature passed several provisions targeted towards CHIP in order to reduce the state's spending. The reductions in state spending on CHIP has resulted in enrollment declining from 529,211 in May 2002 to an estimated 358,230 in June 2004. Enrollment projections for 2005 include another 169,000 children no longer eligible for CHIP. The state decided it was necessary to reduce CHIP funding in order to focus the limited budget on the poorest children enrolled in Medicaid. The purposes of this paper are to examine the CHIP program in Texas and propose legislation that could restore program funding and ultimately reduce the number of children in Texas without health care insurance.

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Children's Health Insurance Program

Funding and Proposed Legislation for Texas

Submitted to:

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TABLE OF CONTENTS

LIST OF TABLES

Table

LIST OF FIGURES

Figure

Abstract

The Children's Health Insurance Program (CHIP) in Texas provides basic health insurance to children less than 19 years of age for families that cannot afford private insurance and do not qualify for Medicaid. Studies have shown a correlation between the lack of health insurance and the negative effect on a child's health status. In 2004, financing of CHIP came to the forefront of debate as Texas struggled to overcome a $10 billion dollar budget deficit. Consequently, the 78th Texas Legislature passed several provisions targeted towards CHIP in order to reduce the state's spending. The reductions in state spending on CHIP has resulted in enrollment declining from 529,211 in May 2002 to an estimated 358,230 in June 2004. Enrollment projections for 2005 include another 169,000 children no longer eligible for CHIP. The state decided it was necessary to reduce CHIP funding in order to focus the limited budget on the poorest children enrolled in Medicaid. The purposes of this paper are to examine the CHIP program in Texas and propose legislation that could restore program funding and ultimately reduce the number of children in Texas without health care insurance.

Introduction

Prior to beginning the analysis, the following quote from Rawls (1971) best describes the overall point of view of this author regarding this policy analysis paper:

> A rational and impartial sympathetic spectator/author is a person who takes up a general perspective: he assumes a position where his own interests are not at stake and possesses all the requisite information and powers of reasoning. So situated he is equally responsive and sympathetic to the desires and satisfactions of everyone affected by the social system. (p. 20)

The significance of providing health care coverage for children cannot be overemphasized. The lack of health insurance and the negative effect on a child's health status is documented. Health insurance is important to a child's access to care and critical to their overall well-being. In 2002, a study conducted by Sheri Eisert, PhD and Patricia Gabow, MD, found kids with health insurance were more likely to have well-child care, dental, and specialty visits and the recommended immunizations than uninsured children. Moreover, insured children are less likely to have an emergency care visit and fewer outpatient visits than uninsured children are.

Health care coverage for children in poor and low-income families is primarily through two social welfare programs. The programs are Medicaid and the State Children's Health Insurance Program (SCHIP or CHIP). Social welfare program defined as organized public or private social services for the assistance of disadvantaged groups (Merriam-Webster Online Dictionary, 2005). According to the National Conference of State Legislatures Forum of State Health Policy Leadership (2005), Medicaid provides health care coverage to the poorest of poor children as well as their parents, pregnant women, and other categories of low-income people

with significant illnesses and disabilities. On the other hand, CHIP provides health insurance coverage only to children from families with low incomes, but incomes that are above Medicaid levels. Medicaid is an entitlement and therefore states must enroll any eligible individual even if the state's Medicaid appropriation has completely spent. However, CHIP is a non-entitlement program and states may cap enrollment if they have expended all of their CHIP funding. Children applying for CHIP coverage are first screened for eligibility for Medicaid, and must enroll in Medicaid if eligible. CHIP coverage begins where children's Medicaid coverage ends, and goes up to 200 percent of the Federal Poverty Level (FPL). The income eligibility requirements are shown in Figure 1. According to the Department of Health and Human Services, the FPL is the minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. FPL varies according to family size and location as shown in Table 1. Each year the FPL is inflation adjusted and published in the form of poverty guidelines. In 2005, families with three children who live in the 48 contiguous states or the District of Columbia and earn greater than $16,090 but less than $32,180 a year qualify for CHIP (Federal Register, 2005). Medicaid, the older of the two programs, is for children whose family income is below the FPL or in some cases depending on the age of the child, just above the FPL.

In 1997, as part of the Balanced Budget Act, Congress passed federal legislation creating CHIP (P.L. 105-33). This was the first major funded health program since 1966 with the adoption of Medicare and Medicaid under President Johnson (Haley, Hawkes, Kenny, Harrington, & Wooldridge, 2003). Congress appropriated $24 billion over 5 years and $40 billion over 10 years to assist states in funding the program. In 2006, CHIP projected cost is an estimated $5.4 billion. Authorization for the program expires at the end of fiscal year 2007. However, President Bush's fiscal year 2006 budget seeks to reauthorize the program.

The goal of CHIP is to provide health insurance to the uninsured children throughout the United States (Orchard Communications Inc, 1999). Title XXI in the Social Security Act allows states the option of expanding Medicare, creating a separate program, or undertaking a combination of both to provide health insurance to children. Initially, many states were slow to implement CHIP and as a result, in the first 18 months of the program, states had used less than 20 percent of the federal financial contribution (Weissert & Weissert, 2002). However, by the end of the 3rd year this would all change with the national enrollment of 3.3 million children or approximately 33 percent of the total population of uninsured children (Weissert & Weissert 2002). As of December 2003, CHIP provided coverage to nearly 4 million children throughout the United States.

The Texas CHIP program began in July 1998 with Phase I. Phase I expanded Medicare for teenagers 15 to 18 years of age in families with incomes at or below 100 percent FPL (Orchard Communications, 1999). Of the estimated 152,385 eligible children, approximately 16 percent enrolled by the end of fiscal year 1998 (FY 1998 Annual Report: Texas Title XXI Program, 1998). In 1999, Phase II of the CHIP program was implemented and for the first time families with children age zero through eighteen at up to 200 percent FPL were eligible to obtain health care insurance (Orchard Communications, 1999). Enrollment steadily increased and peaked in May 2002 with an estimated 529,211 children. Because of joint financing, the cost was estimated at over $207 million to the state and $535 million to the federal government (Dunkelberg & O'Malley, 2004). As shown in Table 2, financial resources vary from state to state. Texas's financial support is primarily through proceeds from tobacco settlement and the state's General Revenue Fund. Arizona, Massachusetts, Oregon, and Pennsylvania tax cigarettes or tobacco to subsidize CHIP. According to the Center for Public Policy Priorities (2003), many

state-subsidized health care programs including CHIP, account for over one-third of an entire state budget. For this reason, future financing of children's health insurance programs continues to be a challenge for not only Texas but all states.

The Children's Health Insurance Program in Texas

In Texas, CHIP remains an accepted program with support among consumers and politicians alike. The program, with its federal matching dollars, relatively low cost per enrollee, success in lowering the number of uninsured children, was not a casualty of early budget cuts in Texas. This changed in 2003 when the Texas General Revenue Fund dropped $7.4 billion. The decrease in sales tax revenue was primarily due to a refusal of state leaders to find new revenue, and a "no new tax" pledge. The 78th Texas Legislature responded to the revenue predicament by passing House Bill 2292 (H.B. 2292). The purpose of H.B. 2292 was to streamline government and reduce costs. The 311-page bill contained numerous cuts to the state's health care services, and the reorganization of twelve agencies into four departments under the leadership of the Texas Department of Health and Human Services Commission (HHSC).

The cuts made to the CHIP program were intended to decrease enrollment by at least 100,000 children and ultimately reduce the amount of revenue spent on the program. H.B. 2292 proved to be extremely effective in reducing CHIP enrollment. Out of the 11 states that experienced a decline in enrollment, Texas showed the single largest decrease of 75,000 children in the second half of 2003. As of Jan of 2005 enrollment has dropped 35 percent to 332,055 children (see Figure 2). Insufficient funding of CHIP has resulted in too many children without health care insurance in Texas. In 2004, an estimated 22 percent of all children in Texas did not have health insurance, ranking Texas last among the 50 states (Castro, Dunkelberg, & McCown, 2003). Kaiser Commission on Medicaid and the Uninsured (2004) forecasted that once Texas

"ends the moratorium on terminations for nonpayment of premiums and applies a new asset limit, the downward decline in enrollment could intensify" (Dunkelberg & O'Malley, 2004, p. 1). In addition, dental, durable medical equipment, chiropractic services, hearing aids, home health, hospice care, mental health, physical therapy, speech therapy, substance abuse services, vision care, and eyeglasses may cease to be a covered benefit. The elimination of these benefits would reduce state spending on CHIP and compromise children's health care even further.

H. B. 2292 reduced CHIP enrollment primarily through eligibility restrictions and benefit reductions. The changes included eligibility restrictions, a reduction in continuous coverage from 12 months to 6 months, establishment of a 90-day waiting period, increase premiums for families with incomes between 101-200 percent FPL, and higher co-payments (Dunkelberg & O'Malley, 2004).

The eligibility changes included elimination of income deductions and a new asset test policy. Removal of income deductions included child support paid out and childcare costs. Consequently, gross rather than net income now determines CHIP eligibility. The change took effect September 1, 2003 and CHIP coverage terminated for children enrolled who fell in the upper income range. A new asset test policy imposed a limit as part of the eligibility regulations for children in families with incomes at or above 150 percent of the FPL. The limit is $5,000 and includes any money in checking or savings accounts plus the value of vehicles (Castro et al., 2003).

Up until fiscal year 2004, children were eligible for twelve months of uninterrupted benefits prior to renewal. This changed from twelve months to every six months. The rationale, albeit creditable, is to transfer CHIP enrolled children with greater frequency to the Medicaid program if they become eligible. If during renewal the family income is low enough to qualify

for Medicaid, the children are transferred to the Medicaid program. If the family income at time of renewal is above 200 percent of the FPL, the children are no longer eligibility for CHIP and seek private health care insurance. September 1, 2005 the six-months of continuous coverage will revert to twelve months.

A new eligibility-waiting period stipulates children certified eligible for CHIP must wait 90 days before coverage takes effect. The purpose of the 90-day waiting period was to reduce what is commonly referred to as *crowd out.* Crowd out is defined as the substitution of publicly funded health insurance for privately funded health insurance. Blewett, Call, Davidson, & Williams (2004) from the Robert Wood Johnson Foundation deem crowd out can take on three forms. First, a person or family drops private insurance to enroll in public coverage. Second, a public program enrollee refuses an offer of private coverage. Finally, someone with public coverage refuses an employer's offer of insurance, which that person would have accepted in the absence of the public program. No studies have been identified on how effective waiting periods are in reducing the crowd out effect. Nevertheless, it is plausible that they are likely to reduce some forms of crowd out. The downside of anti-crowd-out measures is the potential to discourage CHIP eligible individuals from enrolling (Blewett, Call, Davidson, & Williams, 2004). To counter this possibility, exemptions to the 90-day waiting period include involuntary loss of health insurance, good cause determined by HHSC, or available insurance was unaffordable. Unaffordable insurance defined as exceeding 10 percent of net income (Legislative Budget Board, 2004).

Lastly, cost sharing changes on October 1, 2003, affected enrollees whose income is 101 percent to 200 percent of FPL. The monthly premiums, a form of cost sharing required by CHIP since 2000, today is still zero for a family earns less than 100 percent of the FPL. The monthly

premium for the family who earns between 100 and 150 percent FPL increased from $0 to $15 dollars. An additional cost-sharing change for this group included a co-payment cap from $100 dollars to 1.25 percent of income. For those in the next income bracket of 150 to 185 percent FPL, premiums increased from $15 to $20 dollars per month per family member. Finally, those in the 150 to 200 percent FPL, premiums went from $18 to $25 dollars per month per member. All these premium changes have the potential to reduce CHIP enrollment for the reason that some parents could not or worse, would not pay the higher premiums (Center for Public Policy Priorities, 2003). However, the policy changes were alleged to be unavoidable, allowing the state to channel their limit funds to the neediest children who were enrolled in Medicare.

The HHSC, with its limited budget resources, in November 2004, suspended collection of all monthly premiums for CHIP-enrolled families. This despite federal law requires the collection of these premiums in order to reduce the federal and state share of expenditures on the CHIP program. According to a January 2005 report by the Texas Legislative Budget Board, "The General Appropriations Act assumed premiums could be used for the state share of expenditures only and thus assumed more in federal funds than was allowable" (Legislative Budget Board, 2004, p. 129). In June 2004, HHSC submitted a wavier to the Centers for Medicare and Medicaid (CMS) asking the federal law waived. The CMS notified HHSC the federal provision for collection of premiums was prohibited. The Legislative Budget Board estimates the denied wavier cost the state of Texas nearly $23 million in general revenue funds for fiscal year 2004.

The suspension of premiums coupled with the failing to disenroll recipients for nonpayment has resulted in additional costs to the CHIP program. From a political perspective, the decision to temporally suspend monthly premiums and extend deadlines may have been a

popular one. However, from a state that continues to struggle fiscally the decision lacks logic. The HHSC's Legislative Budget Board estimates lost premium proceeds at over $56 million for 2004 and 2005. Additional losses are likely in 2005 depending when or if premiums are restored. Currently, projected premium revenue for fiscal year 2005 is zero. If premiums had not been suspended but collected instead, the revenue if rolled back into the CHIP program could have permitted other children access to health care insurance.

Beyond the state goal of saving money and the impact on those who lost health care benefits, policy changes have resulted in a substantial amount of federal money turned down. In general, a state has three years to spend their federal CHIP allotment. For example, the fiscal year 2003 allotment can be spent in fiscal years 2003, 2004, and 2005. The only exception to the three-year period was in December of 2000 when Congress gave states a two-year extension for their 1998 and 1999 allotments. If a state has not spent the funds within three years, The Department of Health and Human Services redistributes the unused funds to states that depleted their full allotment for that fiscal year. Redistributed funds are available to states for only one year after receiving them. The reallocation process helps assure child health funds are distributed to states that can make use of them to cover children, rather than remaining unspent (Kaiser Commission on Medicaid and the Uninsured, 2001). One final note is the President's fiscal year 2006 budget seeks to decrease the time states have to spend their allotments from three to two years. The change would not only require states to expend their allotments at a faster rate but also in greater quantities or relinquish the funding to other states.

Title XXI of the Social Security Act authorizes payment of federal matching funds. Annually the CMS publishes Federal Register Notices containing the Federal Medical Assistance Percentage (FMAP) or the matching rate, allotment amounts, and redistribution of unspent funds

for each state. Based on the FMAP for Texas in 2005, for every $1 the state spends, the federal government matches with $2.65. The allotments for 2003, 2004, and 2005 are shown in Table 3. The 2003 allotment of $311.5 million will expire at the end of fiscal year 2005 and redistributed to other states if the funds are not spent. To date, Texas has never received unspent funds from other states.

Leveraging state funds to draw down federal funds means for every 100 children Texas finances to receive health care insurance through CHIP, the federal government would provide additional funding to insure an additional 265 Texas children. Since 1998, Texas has missed the opportunity to provide heath care to over 400,000 children by returning an estimated $521 million dollars of federal matching funds. In a recent article published by Ray Perryman, Ph.D. concluded that reductions in state spending are "a losing proposition in that for every dollar saved through cuts, far more is lost in federal funding, insurance premiums, and other associated costs" (Texas Hospital Association, p. 1).

In order for Texas to "leave no money on the table" in 2005, the state would need to spend $418.6 million in revenue to receive the total federal allotment of over one-billion dollars. In the spring 2003 issue of *The Future of Children,* Behrman, Bennett, and Lewit's recommendation to solving the financing issue was "federal and states governments should work together to resolve the funding problems in CHIP to ensure stable and adequate federal funding for CHIP in all states" (p.13). Texas needs to discover an innovative approach to finance CHIP. The state revenue generated when magnified by the federal matching rate will provide the necessary resources to reduce the number of children without health care insurance in Texas.

CHIP Funding Alternatives

Most policy solutions are categorized as either substantive or procedural (Weissert & Weissert, 2002). Substantive policies are used to improve health care whereas procedural polices are concerned with how the government is operating or in this case, the process of obtaining health care. An example of a procedural policy is H.B. 2292 that changed the formula and modified the conditions for CHIP eligibility. This procedural change made it more difficult for families to obtain health care and translated to 169,000 less children receiving health care coverage in 2005.

Polices can be viewed as distributive or redistributive, depending upon how costs are dispersed. Distributive polices diffuse the costs among the taxpayers at large and do not focus on one specific group. In this case, as Weissert and Weissert (2002) point out, the winners have a big stake in the policy, actively support its passage, while the losers do not lose much, and pay little attention. On the other hand, redistributive polices take money from some and give it to others. Traditionally, health care policy redistribution meant taxing those with higher incomes to pay for health services for those with lower incomes. Weissert and Weissert (2002) recognize redistributive politics are fierce, combative, controversial, constantly under attack, hard to obtain, and hard to retain.

Nevertheless, the significance of providing health care coverage for children cannot be overemphasized. Health insurance is important to a child's access to care and critical to their overall well-being. Most people will concur the current trend of reducing CHIP funding can not continue and agree with Texas Representative Naishtat's statement when he said, "CHIP cuts make no sense educationally or economically. I urge the leadership to lead by taking action. Help every child reach his or her potential by ensuring access to health coverage. Place this

important issue on the call. We must restore the cuts to CHIP services immediately" (Texas House of Representatives, 2004, ¶ 9).

Traditionalists in many states are leading the movement against smoking, seeking higher and higher taxes on cigarettes or tobacco in order to restore various services including CHIP. They want smokers to pay for the perceived costs they have inflicted on society. Two such conservatives are Texas Senators Jeff Wentworth and Bill Ratliff who proposed a redistributive policy to increase the tax rate on tobacco. The policy called for increasing the excise tax on cigarettes $1 dollar per pack to balance the state budget and restore the CHIP program. The $1 dollar increase in cigarette tax is projected to generate $1.5 billion dollars in general revenue per year. However, one issue with taxing cigarettes to fund a health care program is simply no one can guarantee an adequate supply of smokers. In actuality, smoking has declined from 42 percent in 1992 to 25 percent in 1993 and continues to decline today (National Center for Policy Analysis, May 1997). One component of the decline can be attributed to the price responsiveness of smokers exhibiting a demand elasticity of -0.4 to -0.7, which means that a 10 percent increase in cigarette prices will lead smokers to cut back on the quantity purchased by four to seven percent (Viscusi, 2003).

As pointed out in 1997 by the National Center for Policy Analysis, another dilemma with a regressive cigarette tax is that it discriminates against low-income and minority populations (National Center for Policy Analysis, May 1997). The poor and minority often pay a higher percentage of their income in taxes than do the wealthy. The regressive nature of cigarette taxes has these two groups paying a much higher absolute level of taxes than the wealthy. In 1990, people who made under $10,000 per year paid almost twice as much in cigarette taxes as those who made $50,000 and above (Viscusi, 2003).

An additional argument proponents make for increasing the cigarette tax is smokers increase the cost of providing health care and therefore should pay additional fees to offset the cost to non-smokers. However, according to a study conducted by Manning, Keeler, Newhouse, Sloss, and Wasserman (1989) smokers already pay their own way. In 1989, Manning et al. found the combined 1989 federal and state tax of 37 cents per pack was more than double the 15 cents direct cost of smoking. A more recent publication, *The New Cigarette Paternalism* by Kip Viscusi from the Harvard Law School, suggests smokers pay an estimated 88 cents more per pack than they cost society in health care and higher insurance costs (2003). Further evidence smokers pay their own way can be found in economics literature where the consensus is, after discounting at a rate of three percent, cigarette smokers more than pay their own way (Viscusi, 2003). Many studies that inflate the cost of smoking fail to take into account the excise taxes and the lower demands smokers place on pension and health plans. On average, smoking either pays for itself or generates revenues for many states. The argument that suggests that cigarette or tobacco taxes have to be increased dramatically to cover the costs generated by their consumers is simply misleading and lacks justification.

Lastly, a contradiction exists between taxing tobacco, the single largest health risk, and funding a health care program. Texas and many other states have spent millions of tobacco settlement dollars to combat tobacco use. In 1999, the 77th Texas legislature passed House Bill 1676, which created a $200 million permanent fund for tobacco education and enforcement to reduce the use of cigarettes and tobacco products. The Texas Department of State Health Services spends the funds on tobacco use cessation, public awareness programs, enforcement of tobacco laws, and programs for communities traditionally targeted by the tobacco industry (Huang, 2001). Texas is now contemplating joining Arizona, Massachusetts, Oregon, and

Pennsylvania in taxing the very product they spent millions of dollars to prevent. Texas in general and the Department of State Health Services specifically will in essence be saying that smoking is acceptable and essential in order to fund a children's health care program.

A second redistributive policy often proposed is the utilization of lottery monies to fund CHIP. This option was rapidly disqualified since lottery money is already labeled for specific federal poverty purposes. Pursuing this option would require competition with other designated recipients and not be conducive to a timely and permanent solution to fund CHIP.

Amy Frantz (2003) points out in her article titled *Excise Taxes: A Tool of the Politically Powerful*, "the best case that can be made for using the excise tax is only when the revenue from an excise tax is earmarked for a specific benefit to taxpayers, and there is clearly a link between the tax and the benefit" (p. 2). Other unsubstantiated solutions for funding the CHIP program include sales and franchise taxes, taxing the revenue from legalize video gaming, tax revenue generated by hospitals, doctors and other providers, and implementing a tax on low government utilization hospitals.

A feasible alternative is for the Texas legislature to pass into law a new redistributive tax bill to fund the CHIP program. The new tax would need to a have a correlation between the taxpayer and potential CHIP beneficiaries. There would be as Frantz points out "a link between the tax and the benefit." The revenue collected from the new tax would be distributed back into CHIP and not take funding from any existing entity or program. The likely outcome would be ensuring more Texas children receive the necessary health care services and have a better chance of being healthy and staying healthy (Goodspeed, 1997). A subsequent result is the state will no longer be considered a donor state and tax dollars spent in Texas will provide health care to the children of Texas.

The idea of an excise tax or consumption tax has been around for at least 500 years (Caldwell, 2004). The philosopher Thomas Hobbes wrote in *Leviathan* that taxing what people consume is fairer than taxing what they earn (Hobbes, 1651). The former, he thought, represented what people take out of society, while the latter showed what they contributed. Sir William Petty (1662) made a similar point for consumption tax when he said, "Every man should pay according to what he actually enjoyeth" (p. 47). In the 18th century, David Hume argued that a principal benefit of consumption taxes is that they are to a certain extent voluntary, because people can choose whether to consume the taxed commodity (Hume, 1777).

Excise taxes are consumption taxes on the sale of particular products and in most cases classified as consumer fees (Bartlett, 2003). For example, the excise tax on airline tickets is used to support development of airports (Forsberg, N.D.). The government taxes gasoline to raise revenue necessary to maintain the roads (McGee, 1998). Therefore, those who purchase gas or airline tickets pay the tax and those who do not purchase these items do not pay the tax.

One reason for the disapproval of excise taxes is they are seen as having a greater impact on the low-income, near poor, and poor families. Medicaid defines low-income as less than 200 percent FPL, near poor between 100 percent and 199 percent FPL, and poor below 100 percent FPL. Research has indicated these particular classes of people often consume more alcohol and tobacco products than other families (McGee, 1998). It stands to reason then the impact on the low-income, near-poor, and poor is the direct result of consumption habits and not the tax itself. If they do not pay the tax, then who should? Wealthy people who do not consume alcohol or smoke tobacco do not pay excise taxes on alcohol or tobacco products. McGee (1998) surmises there is nothing inherently wrong about not paying a tax for something you do not consume. From an equity standpoint, there appears little justification for making the taxpayer pay for a

service that yields direct and immediate benefits to certain individuals (Garrett, 2002). Equity is the distribution of taxes according to a principle of fairness and not equality. Equality is a public state of affairs in which different people have the same social status. Cost-benefit analysis is the economic standard on which taxes are measured. This type of analysis provides a means of establishing a levy in a way that places the tax burden primarily on the recipients of the benefit.

In order for a new policy to be viable, it must be politically acceptable, or at least unacceptable according to Bardach (2000). Bardach (2000) points out that political unacceptability is a combination of two things: too much opposition and/or too little support. In 2003, Senate Majority Leader Don Perata of California suffered from both effects when he introduced and shortly thereafter, withdrew a quarter-cent tax bill on disposable diapers to offset the cost of landfills (Taugher, 2003). The fees collected would have gone into a fund that cities and counties would use to set up recycling and composting programs (Taugher, 2003).

Contributing to the proposal's unacceptability was the taxpayer alone had to bear the entire cost with no federal assistance or matching funds. Some parents objected to the idea of placing a new tax on disposable diapers because they felt it penalized parents for what they see as a non-discretionary expense. Sarah Kelly, a Vallejo physical therapist and mother of 2-year-old twins summed it up when she said, "It's the responsibility of our entire culture because all kids have to be diapered" (Taugher, 2003, p. 1). Thomes Hobbes, Sir William Petty, David Hume and Ronald Dworkin would all disagree with Kelly. Dworkin (1981), a resource-based theorist, proposes that people begin with equal resources but end up with unequal economic benefits as a result of their own choices. Moreover, others feel its reasonalby acceptable to tax those who receive the benefit of the tax.

CHIP Funding Proposal

A new Texas legislative bill that taxes disposable diapers, dubbed the Children's Health Insurance Tax (CHIT), is a way of reducing the number of children in Texas without health care insurance. Based on the rationale of consumption theory, equity principal and cost-benefit analysis, it appears reasonable to tax a specific consumer product that current or potential CHIP enrollees purchase. A disposable diaper is defined as a garment for infants and young children made of absorbent material that is not reusable on the infant or young child. Parents with children in diapers and utilize CHIP, the added expenditure is necessary for the state to maintain their health insurance. Individuals who have no need to purchase diapers would continue to support Texas children through a variety of other measures including property, sales, and motor fuel taxes. Finally, Rachels (1989), in his paper *Morality, Parents, and Children* makes an argument directed primarily at parents who purchase diapers but have private insurance and no current need for CHIP. He argues "They (parents) have a responsibility to provide for the needs of every child in the world" (p. 159). He answers the question of how should parents who are concerned to do what is morally best, envision the relation between their obligations to their own children and their obligations to other children with the following:

> Partial bias recognizes that while we do have a substantial obligation to be concerned about the welfare of all children, our own nevertheless comes first. When considering similar needs, you may permissibly prefer to provide for the needs of your own child. For example, if faced with a choice between feeding your own children or contributing the money to provide food for other children, you would rightly choose to feed your own. However, if the choice were between some relatively trivial thing for your own and necessities for other children, preference should be given to helping others. Thus if the

> choice were between providing trendy toys for your own already well-fed children or providing necessities for other children, preference should be given to helping the others. You may provide necessities for your own children first, but you are not justified in providing them luxuries while other children lack necessities (p. 160).

The overall public support of a new redistributive tax policy and parents adopting a partial bias approach would signify choosing to make health care available for more children in Texas. CHIT would be a short duration fee only assessed while the child is diapering, which according to Lenzie (2002), is on average three years. The purpose of CHIT is to generate and ultimately spend state funds necessary to draw down all federal funds designated for Texas CHIP. The combination of state spending and federal fund contributions could result in more children in Texas receiving health care insurance through CHIP.

Course of Action

The first course of action to pass the CHIT bill into law begins with presenting the idea to a state senator or representative. The approach can be as simple as a phone call or presentation of this policy analysis paper. If the initiative were to be accepted, the CHIT bill would have reached its first milestone and now be introduced at a legislative session. The third step in the process allows public participation during the House and Senate committee debate. If the committee has reported the CHIT bill favorably, the bill becomes available for placement on a legislative calendar. The calendar is a list of bills and resolutions scheduled to be considered by the full house or senate. Once the bill pass the both the house and the senate, it may be signed or vetoed by the governor or pass without signature and become law. If the CHIT proposal was rejected by the Texas legislature at anytime in the process, at least two alternatives are available. First, present the proposal to the state legislature at a different point in time when the governing

members have changed. Second, propose the idea to another state elected representative. While the Texas state legislature may reject the idea, another more progressive state may accept the proposal and take it forward.

The proposed bill would read "The tax shall be paid by the person purchasing from a manufacturer, wholesaler, seller, supplier, or distributor for sale to a consumer within the state of Texas" (Appendix A). Manufacturers, wholesalers, sellers, suppliers, and distributors of diapers would retain zero percent of the revenue generated by the tax to cover the administrative costs of processing and paying the tax. The rate is based on other states including California, New York, and Wisconsin that provide no such relief for administration of various tax collections (Legislative Budget Board, 2004).

Discussion

In 1989 and 1990, Procter & Gamble, makers of Luvs and Pampers disposable diapers, funded two major lifecycle analysis studies of disposable diapers (Lenzie, 2002). As shown in Table 4, averages for diapering period and number of changes per day determined the average total number of diapers consumed per year.

The CHIP enrollment scenario analysis is based on a two, four, and eight-cent tax shown in Table 5. Texas Census Data reported the number of children five years old and below, therefore, in order to arrive at the number of children age three and below, an equal age distribution was assumed. Projected revenue based on an eight-cent tax and the federal matching funds of $2.65 totals over $503 million. The revenue generated has the potential to provide health insurance to more children. Depending on which year the legislature passes the tax, Texas would capture the entire 2003 or 2004 federal allotment money without having to spend any additional state funds. The bottom-line, an eight-cent state tax combined with federal matching

money will allow 400,000 children the opportunity to receive the necessary health care services vital to living healthy lives with out dependence on other state financing.

When compared to various other taxes paid in Texas, CHIT is relatively inexpensive. For example, gas tax is 20 cents per gallon or 250 percent higher than the proposed CHIT. The current cigarette tax is 500 percent higher at 41 cents per pack than the proposed CHIT. Finally, an individual purchasing a gallon of liquor will pay 3000 percent more than the proposed tax. Furthermore, when a consumer purchases items like gas, cigarettes, or liquor the federal government contributes no matching funds. In fact, the opposite often occurs with the federal government adding additional taxes.

Opponents of the proposed CHIT may have concerns about families in the lower tax brackets that may not be able to afford the proposed levy. A potential solution is for the federal government to work together with the states and allow qualified families under the Earned Income Tax Credit (EITC) a deduction for the cost of CHIT. Several factors determine eligibility and amount of EITC including total family earned income. The Department of Treasury Internal Revenue Service defines earned income as all the taxable income and wages you receive from working to include wages, salary, tips, and other compensation earned from employment. In 2004, parents working and raising one child in their home and had earned income of less than $30,338 ($31,338 for married) can collect an EITC of up to $2,604. Working parents who were raising two or more children in their home and had earned income of less than $34,458 ($35,458 for married) in 2004 can receive an EITC of up to $4,300 (Department of Treasury Internal Revenue Service, 2004). The intent of the EITC is to decrease or eliminate the tax bills of low-income families and individuals who have taxable income. The

CHIT deduction, if permitted, would contribute to decreasing a family's tax bill and in all likelihood, result in a larger federal tax credit.

An alternative for parents is to adopt Hume's philosophy of consumption taxes being voluntary and choosing to switch from the discretionary expense of disposable to cloth diapers. The parents who elect cloth diapers will not have to pay the proposed tax. The parents will not only avoid the tax but also perhaps save some money in doing so. Doctor Schmitt (2004), author of *Your Child's Health*, estimates disposable diapers cost on average about 20 cents per diaper and cloth diapers from a diaper service cost about 12 cents. Schmitt surmizes, after the initial purchase, if you launder the diapers yourself the cost is reduced to as little as 3 cents per diaper. Other parents may elect a combination of both cloth and disposable diapers. In the end, both the diapering method and whether or not to pay the tax is entirely up to the parent.

Conclusion

The value of CHIP in Texas cannot be overstated and not many people will question the vital services provided by the program. Children who are enrolled in CHIP are more likely to receive preventive care services and less likely to use emergency care than uninsured children. Therefore, it is incumbent upon the Texas state legislature to adequately fund CHIP. If political conditions become more favorable and politicians would move away from a "no new tax" philosophy then sufficient funding for CHIP could by achieved through a supplementary excise tax. The financial advantage gained by using state dollars to draw down federal money would result in more children eligible to receive health care.

Parents and legislators alike must ask themselves where their values lie. They must ask whether they value money over the impending issue of too many children in Texas without

health care coverage. They must ask themselves whether they feel, based upon the research shown in this study, if the benefits obtained from a tax outweigh the cost.

Recommendation

Every parent in Texas willing to spend an extra few cents would mean one more insured child. The state must spend the necessary state funds to capture all federal allotment monies available. Otherwise, eligible children will go without health care. For as little as two-cents, the proposed legislature will generate the necessary revenue for Texas to spend on CHIP and most likely result in a greater number of children having health care insurance under CHIP.

Appendix

PROPOSED LEGISLATION

A BILL TO BE ENTITLED

AN ACT

establishing a Children's Health Insurance Tax (CHIT).

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

This bill establishes a tax of $.08 on each disposable diaper sold at retail in Texas. The person purchasing from a manufacturer, wholesaler, seller, supplier, or distributor for sale to a consumer within the state Texas shall pay the tax.

SECTION 1. Section 11.01, Tax Code, is amended to read as follows:

a). For the purpose of funding the Children's Health Insurance Program (CHIP) there is hereby established a disposable diaper tax. The tax imposed by this section is in addition to any other taxes. The commissioner shall administer this tax.

b). The person purchasing from a manufacturer, wholesaler, seller, supplier, or distributor of a disposable diaper for sale to a consumer within the state shall be liable for and shall pay the CHIT to the department.

SECTION II. Effective January 1, 2006, a tax of $.08 shall be levied on each disposable diaper sold at retail in Texas.

a). Each person who purchases from a person engaged in manufacturing, selling, supplying, or distributing disposable diapers for sale to a consumer within the state during a taxable period shall, on or before the fifteenth day of the first month following the expiration of the taxable period, make a return to the commissioner under such regulations and in such form or manner as the commissioner may prescribe. Returns shall contain full data as required by the commissioner for correct computation of the tax hereunder. All returns shall be signed by the taxpayer or by his authorized representative, subject to the pains and penalties of perjury.

b). Any person who fails to file any return at the time prescribed in this section shall pay at the time the return or declaration is filed, in addition to any tax liability and without assessment or demand, a late filing fee of $100 for each day or fraction thereof which has elapsed between the prescribed filing date and the date of actual filing.

Table 1

Department of Health and Human Services Poverty Guidelines for 2005

Persons in Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$9,570	$11,950	$11,010
2	$12,830	$16,030	$14,760
3	$16,090	$20,110	$18,510
4	$19,350	$24,190	$22,260
5	$22,610	$28,270	$26,010
6	$25,870	$32,350	$29,760
7	$29,130	$36,430	$33,510
8	$32,390	$40,510	$37,260
For each additional person, add	$3,260	$2,080	$3,750

Note. Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

Table 2

Children's Health Insurance Program Funding Source by State/Jurisdiction

State/Jurisdiction	State Funds
Alabama	General fund; three state agencies provide financial match for AL-Kids Plus
Alaska	General fund
American Samoa	General fund
Arizona	Tobacco tax
Arkansas	General fund
California	General fund; state funds expand Healthy Families coverage
Colorado	General fund; intergovernmental transfers from disproportionate share hospitals
Connecticut	General fund
Delaware	General fund
District of Columbia	General fund
Florida	General fund; tobacco settlement trust fund; county contributions for Florida Healthy Kids
Georgia	General fund
Guam	General fund
Hawaii	General fund
Idaho	General fund
Illinois	General fund
Indiana	General fund; tobacco settlement
Iowa	General fund
Kansas	General fund
Kentucky	General fund
Louisiana	General fund
Maine	General fund
Maryland	General fund
Massachusetts	General fund; cigarette tax revenue; children's and seniors' health care fund revenue
Michigan	General fund
Minnesota	General fund
Mississippi	General fund
Missouri	General fund
Montana	General fund; private donations; intergovernmental transfer from the commissioner of insurance
Nebraska	General fund
Nevada	General fund
New Hampshire	General fund; donations from the Healthy Kids New Hampshire Foundation
New Jersey	General fund
New Mexico	General fund
New York	Indigent Care Pool Fund
North Carolina	General fund
North Dakota	General fund

Northern Mariana Islands	General fund
Ohio	General fund
Oklahoma	General fund
Oregon	Tobacco tax
Pennsylvania	General fund; cigarette tax
Puerto Rico	General fund
Rhode Island	General fund
South Carolina	General fund; intergovernmental transfer; Department of Health & Human Services funds
South Dakota	General fund
Tennessee	General fund
Texas	**Tobacco settlement proceeds, General Fund**
U.S. Virgin Islands	General fund
Utah	Hospital assessment reauthorization
Vermont	General fund
Virginia	General fund; the Virginia Children's Medical Security Insurance Plan (VCMSIP) Trust Fund
Washington	Health Services Account
West Virginia	General fund
Wisconsin	General fund
Wyoming	General fund

Note. Health Care Financing Administration; National Conference of State Legislatures and National Governors' Association, *State Children's Health Insurance Program Annual Report*, 1999.

Table 3

CHIP Federal Allotment Dollars Available in Texas for Fiscal Year 2005

Fiscal Year	Federal Allotment For CHIP ($ Million)	Enhanced Federal Medical Assistance Percentage	Matching Rate	State Funds Necessary to Obtain Allotment
2003	$311.5	71.99	$2.57	$121.2
2004	$330.8	72.15	$2.59	$127.7
2005	$449.9	72.61	$2.65	$169.7
Total	$1,092.2			$418.6

Note. Federal Register / Vol. 70, No. 12 / Wednesday, January 19, 2005 / Notices. The Enhanced Federal Medical Assistance Percentages for Fiscal Year 2003, 2004, 2005

Table 4

Lifecycle Analysis Study of Diapers

	Disposable Diapers (Lentz)	Disposable Diapers (Little)	Average
Diapering Period (years)	3.5	2.5	3
Number of Changes per day	3.3	6.4	4.85
Number of diapers used per infant per year	1,205	2,336	1,770

Note. From Diapering Decisions, by C. Lenzie, Washington State University

Table 5

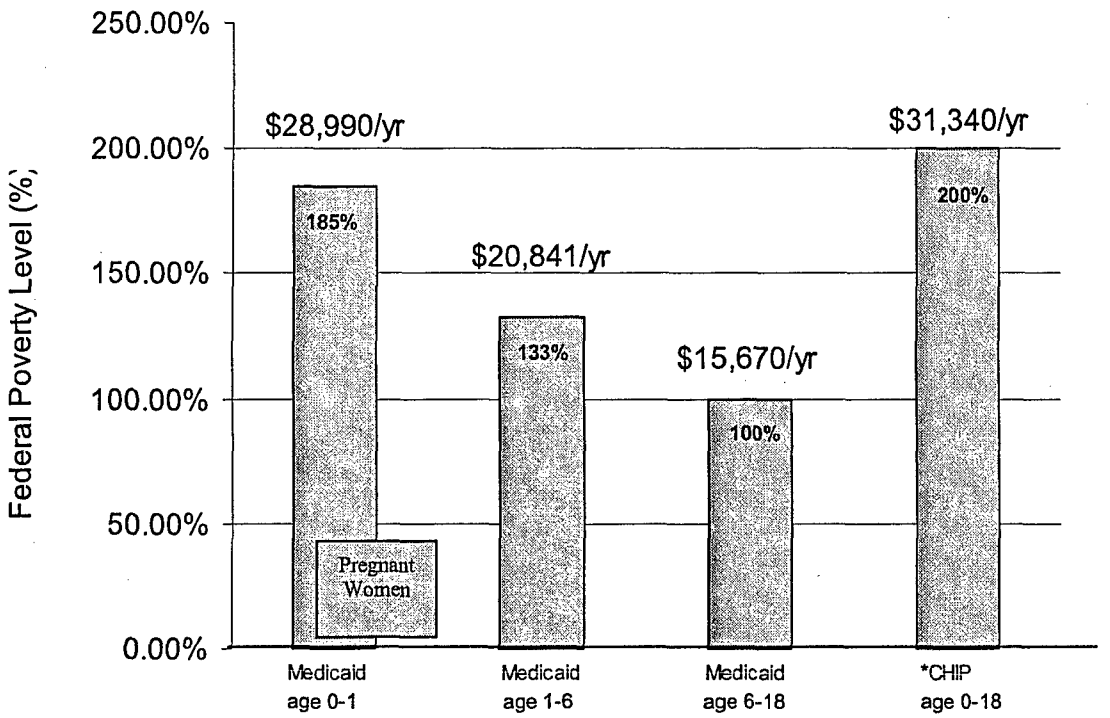
Projected Number of CHIP Enrollees based on Excise Tax Amounts

Excise Tax Amount	Average Diaper Usage/Child/Year	Total Cost/ Child/ Year	Number of Children in Texas (< 3 yrs old)[a]	State Revenue from CHIT	Federal Matching Funds[b]	Total Revenue	Average Cost/Child Enrolled in CHIP[c]	Number of Potential Enrollees
$0.02	1770	$35	974,777	$34,507,106	$91,443,830	$125,950,936	$1,257	100,200
$0.04	1770	$71	974,777	$69,014,212	$182,887,661	$251,901,872	$1,257	200,399
$0.08	1770	$142	974,777	$138,028,423	$365,775,321	$503,803,745	$1,257	400,799

[a]Values are based on equal distribution of children under the age of 5 years old in Texas (1,624,628). [b]Based on 2005 Federal Matching Fund of $2.65. [c]Average cost per child enrolled in CHIP for 2003/2004.

Figure 1

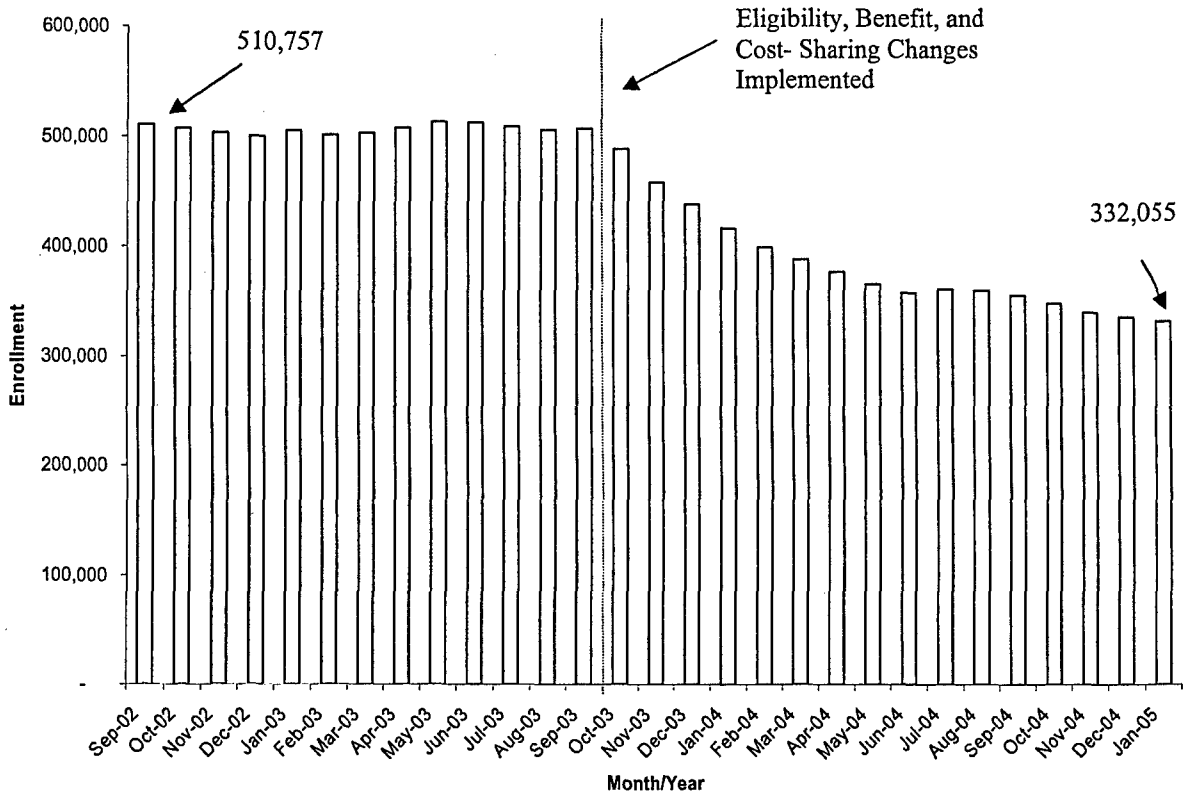
Federal Poverty Level Eligibility Requirements in Texas Medicaid and CHIP, 2004.



Note. Children eligible for Medicaid may not enroll in CHIP. Numbers represent annual income levels for a family of three. From http://www.cppp.org/products/alertsflyers/healthflyers/whogetsMC.pdf

Figure 2

Texas State Children's Health Insurance Program (SCHIP) enrollment, September 2002 – September 2004.



Note. From the Texas Health and Human Services Commission (http://www.hhsc.state.tx.us/research/CHIP/ChipRenewStatewide.html)

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